

Plan Administered by:



COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

For Toll-free Policyholder Service
1-800-756-3702
Utica area 315-797-5200

Please check the correct Underwriting Company:

- ☐ COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
☐ SECURITY MUTUAL INSURANCE COMPANY OF NEW YORK

Instructions

1. PART A — must be completed by the school.
2. PART B — must be completed by Parent or Guardian
3. Attach all itemized medical bills you have received to date. Later bills can be mailed to the claims administrator separately. Please show name of school on all later bills.
4. Mail this report and bills within 90 days after the first treatment to:

Special Risks Claims
Commercial Travelers
Mutual Insurance Company
70 Genesee Street
Utica, NY 13502

Accident Claim Form

Please print or type

Part A: School Report

Instructions — school official completes this Part A, then gives the form to the student's parent or guardian to complete Part B on the reverse side. **Parent must provide name of school/school district, if not school related accident.**

If you have submitted an accident report to another insurance company, please attach a copy.

Name of School		School District/Policyholder	
Phone No. ()			
Address			
Street/Box#	City	State	Zip
Name of Student		Policy No.	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade
Date of Accident / /	How Accident Occurred		
Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Enroute to/from school		
	<input type="checkbox"/> During school session		
	<input type="checkbox"/> Practice or play of interscholastic sports		
	Name of Sport _____ <input type="checkbox"/> JV <input type="checkbox"/> Varsity		
<input type="checkbox"/> Other _____			
How did accident happen?			
Details of Injury — including part of body injured:			
Name of Teacher or Coach Supervising the Activity			
Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime (in FL, a felony in the third degree), and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.			
Signature of School Official/Title		Date Signed	

Accident Claim Form
Please print or type

Part B: Statement of Parent or Guardian

Name of Injured Student	Social Security No.	Date of Birth / /	Date of Accident / /
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Name of Person Making this Report	Relationship to Student
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Address Street/Box# City State Zip	Telephone Home () Work ()
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Name of Student's Male Parent or Guardian	Occupation	Social Security No.
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Address if different from student

Employer's Name and Address

Name	Street/Box#	City	State	Zip	Phone #
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Name of Student's Female Parent or Guardian	Occupation	Social Security No.
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Address if different from student

Employer's Name and Address

Name	Street/Box#	City	State	Zip	Phone #
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Does either parent or guardian have Accident/Health Insurance which covers this student? ☐ Yes ☐ No
If yes, which person(s)

Name of Insurance Company(ies)	Name of Policyholder(s)
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For Around-the-Clock Coverage only:

Date of injury (or) onset of sickness _____ When was physician first consulted? _____

Nature of injury (or) illness _____

If injury, how and where did accident occur? _____

Have you suffered same or similar condition in the past? ☐ Yes ☐ No If 'Yes,' and if you were treated for, it, please give name and address of the physician who treated you _____

Dates treated _____

Give name, address and telephone number of usual family physician _____
Phone _____

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked on the reverse or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company checked on the reverse or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of Student _____

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime (in FL, a felony in the third degree), and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Parent or Guardian	Date Signed
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